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ABSTRACT

Included in this report on the Southern Rural Health Conference (held in Nashville, Tennessee in 1976) are: (1) an introduction (details the conference goals); (2) a program agenda; (3) "Summation: Southern Rural Health Conference" (a speech); (4) "Health Care and Rural Development" (a speech); (5) "Innovative Approaches to the Delivery of Primary Health Services in the Rural South" (a speech); (6) recommendations made by the conference task forces (Utilization of Primary Health Practitioners; Group Practice in Rural Areas; Student Organizations and Medical School Rural Health Activities; Innovative Governmental Programs; Environmental and Preventive Health; Education of Health Professionals in Rural Areas; Financing of Health Care; Minority and Women's Health Concerns; Health Planning and Resource Development; and Legal Implications and Problems); (7) a participant list (275 people attended the conference including rural health experts, members of health agencies, educators, legislators, doctors, primary health practitioners, and concerned citizens). Among the task force recommendations highlighted in the summary are: Medicare, Medicaid, private health insurance policies, and a national insurance program should cover primary health center services; health resources development should be tied directly to national health insurance; rural-urban inequities should be addressed by equalizing payments for services under public financing programs. (JC)

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Report and Recommendations

of the Southern Rural Health Conference

October 10-12, 1976
Nashville, Tennessee

U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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Sponsored by: National Rural Center, Washington, D.C.
Southern Regional Council, Atlanta, GA
Office of Continuing Education in Health Sciences,
University of North Carolina at Chapel Hill, Chapel Hill, NC

REPORT AND RECOMMENDATIONS

OF THE

SOUTHERN RURAL HEALTH CONFERENCE

October 10 - 12, 1976
Nashville, Tennessee

Sponsored by:

National Rural Center, Washington, D.C.

Southern Regional Council, Atlanta, GA

Office of Continuing Education in Health Sciences,
University of North Carolina at Chapel Hill, Chapel Hill, NC

December 6, 1976

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INTRODUCTION

The Southern Rural Health Conference was the first regional meeting designed to address a wide range of health policy issues related to the delivery of health and medical services in the rural South. Over 250 people attended the two and one-half day meeting held October 10-12, 1976, in Nashville, Tennessee. These included health providers, consumers, administrators, public officials, policy makers, and representatives of agencies, educational institutions, and organizations involved in rural health care activities.

The conference was a direct outgrowth of the Rural Health Project, a major research study conducted for the Task Force on Southern Rural Development in 1975. This study, headed by Dr. Ray Marshall of the University of Texas at Austin and Dr. Karen Davis of the Brookings Institution, examined ways in which health care needs and conditions in the rural South differ from those of other areas. The findings of the Rural Health Project were used to develop recommendations on health and nutrition contained in the preliminary report of the Task Force which was distributed at the conference.

The co-sponsors of the conferece in collaboration with Drs. Davis and Marshall designed the program to accomplish the following goals:

1. A primary objective of the conference was to initiate dialogue between a broad cross section of individuals committed to the improvement of health of people living in southern rural areas. The conference setting provided the opportunity for participants to establish contact with individuals from other areas and to exchange information and ideas concerning ways of accomplishing common goals.

2. Six innovative health care delivery models were reviewed in order to demonstrate the success of alternative means of meeting the health needs of rural residents. These projects included a variety of models and represented different methods of financing, staffing patterns, and program services. A panel of project representatives which is identified in the program agenda briefly discussed some of these alternative methods.

3. The conference also recognized the need to discuss the importance of increased citizen participation in developing ongoing health care systems responsive to rural community health needs. Representatives from several rural communities shared their experiences in two informal discussion groups dealing with the role of local citizens in self-help community based efforts.

4. The conference also provided the opportunity for establishment of informal state coalitions to advocate improvement of rural health conditions within individual states. These state networks should promote communication between individuals within each state and, hopefully, will be a first step in developing their potential to affect positive change

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at the state level.

5. A basic objective of the conference was the recommendation of specific ways in which current health policies might respond more effectively to the special needs of southern rural residents. Task group sections based on ten issue areas identified from the Rural Health Report met to react to the recommendations set forth in the study and to give additional support and direction for policy change. The recommendations were presented to the entire conference for review and were adopted at the final plenary session.

The report of this conference has been published and distributed as an additional means of stimulating positive policy change at the local, state, and national levels. It is anticipated that the recommendations contained in this document will provide substantial grist for both public and private action to alleviate some of the health problems faced by people living in southern rural areas.

SOUTHERN RURAL HEALTH CONFERENCE

PROGRAM AGENDA

Sunday, October 10, 1976

9:00 a.m. - 1:00 p.m. — Registration Lobby, Sheraton Hotel, Nashville, TN.

1:00 p.m. — General Session

Conference Opening
Dr. Ralph H. Boatman, Director, Office of Allied Health Science and Continuing Education in Health Sciences, University of North Carolina at Chapel Hill.

Conference Presider
Dr. Alexander Heard, Chancellor, Vanderbilt University; Chairman, Task Force on Southern Rural Development, Nashville, TN.

Conference Convener
Dr. Lloyd C. Elam, President, Meharry Medical College, Nashville, TN.

1:15 p.m. — "Health Care and Rural Development"
Dr. Ray Marshall, President, National Rural Center; Director, Center for the Study of Human Resources, University of Texas at Austin, Austin, TX.

1:45 p.m. — "Innovative Approaches to the Delivery of Primary Health Services in the Rural South"
Dr. Karen Davis, Senior Fellow, The Brookings Institution, Washington, D.C.

2:30 - 5:30 p.m. — Rural Health Care Delivery Models
A presentation of six innovative models of health care delivery in the South.

Group Practice
Laurie Dornbrand, M.D., Staff Physician, East Kentucky Health Services Center, Hindman, KY.

Health Maintenance Organization
Mr. Dan Hawkins, Administrator, Su Clinica Familiar, Raymondville, TX.

Primary Health Center
Mr. Jim Bernstein, Chief, Office of Rural Health Services, Department of Human Resources, Raleigh, NC.

Medical Student Staffed Clinics
Wilmer J. Coggins, M.D., Chief, Division of Rural Health; Professor, Department of Community Health and Family Medicine, School of Medicine, University of Florida, Gainesville, FL.

National Health Service Corps/Rural Health Initiatives
Mr. Steve Wilson, Administrator, Lowndes County Health Services Association, Hayneville, AL.

Comprehensive Health Center
Mr. Olly Neal, Director, Lee County Cooperative Clinic, Marianna, AR.

7:30 p.m. Panel Presentation
"Rural Health and Community Development"
Presiding: Bill Dow, M.D., Director, Center for Health Services, School of Medicine, Vanderbilt University, Nashville, TN.

Monday, October 11, 1976

9:00 a.m. Orientation to Task Groups
Bill Dow, M.D., Director, Center for Health Services, School of Medicine, Vanderbilt University, Nashville, TN.

9:30 a.m. Task Group Meetings

Utilization of Primary Health Practitioners
CHAIRPERSON: Mr. Dick Achuff, Division of Primary Care, Department of Public Health, Nashville, TN.

RESOURCE PERSON: Mrs. Rose Littlejohn, Nurse Practitioner, Hot Springs Health Program, Hot Springs, NC.

Group Practice in Rural Areas
CHAIRPERSON: Dr. Ray Marshall, National Rural Center; Center for the Study of Human Resources, University of Texas at Austin, Austin, TX.

RESOURCE PERSON: Donald Madison, M.D., Rural Practice Project, School of Medicine, University of North Carolina at Chapel Hill, Chapel Hill, NC.

Student Organizations and Medical School Rural Health Activities
CHAIRPERSON: Bill Dow, M.D., Center for Health Services, School of Medicine, Vanderbilt University, Nashville, TN.

RESOURCE PERSON: Daniel Blumenthal, M.D., Department of Preventive Medicine and Community Health, School of Medicine, Emory University, Atlanta, GA.

Innovative Governmental Health Programs
CHAIRPERSON: Dr. Michael Samuels, Bureau for Community Health Services, Health Services Administration, Department of Health, Education, and Welfare, Washington, D.C.

RESOURCE PERSON: Ms. Nancy Raybin, St. Charles Health Council, St. Charles, VA.

Environmental and Preventive Health
CHAIRPERSON: Aaron Shirley, M.D., Jackson-Hinds Comprehensive Health Center, Utica, MS.

RESOURCE PERSON: Chester Douglas, D.D.S., Dental Research Center, School of Dentistry, University of North Carolina at Chapel Hill, Chapel Hill, NC.

2:00 p.m. Task Group Meetings

Education of Health Professionals in Rural Areas
CHAIRPERSON: Mr. I. Glenn Wilson, Area Health Education Centers Program, School of Medicine, University of North Carolina at Chapel Hill, Chapel Hill, NC.

RESOURCE PERSON: Robert Graham, M.D., Bureau of Health Manpower, Department of Health, Education, and Welfare, Washington, D.C.

Financing of Health Care
CHAIRPERSON: Dr. Karen Davis, The Brookings Institution, Washington, D.C.

RESOURCE PERSON: Ms. Marie Cirillo, Department of Rural Development, Clairfield, TN.

Minority and Women's Concerns
CHAIRPERSON: Ms. Melba McAfee, Black Belt Community Health Center, Epes, AL.

RESOURCE PERSON: Ms. Connie Juzwiack, Holmes County Health Improvement Project, Lexington, MS.

Health Planning and Resource Development
CHAIRPERSON: Brian Biles, M.D., Senate Health Subcommittee, Washington, D.C.

RESOURCE PERSON: Mr. Benny Thompson, Mayor, City of Bolton, Bolton, MS.

Legal Implications
CHAIRPERSON: Mr. David Warren, Department of Health Administration, Duke University, Durham, NC.

	Legal Implications (Continued) RESOURCE PERSON: Mr. John Williams, East Tennessee Research Corporation, Jacksboro, TN.
7:00 p.m.	Organization of State Networks Mr. Bill Corr, East Tennessee Research Corporation, Jacksboro, TN. Ms. Alice Hersh, National Rural Center, Washington, D.C.

Tuesday, October 12, 1976

9:00 a.m.	Presentation of Task Group Recommendations Presiding: Raymond Wheeler, M.D., Past-President, Southern Regional Council, Charlotte, NC.
12:00 noon	Conference Summary Raymond Wheeler, M.D.
12:30 p.m.	Adjournment

SUMMATION

SOUTHERN RURAL HEALTH CONFERENCE

Raymond Wheeler, M. D.

Health care is a national problem. Why then have we focused our attention on the rural South? General death rates are 22 percent higher in the rural South than the nation; the life expectancy of migrant farmworkers is 49 years, 23 years less than the national average; infant mortality rates are higher than the national average for both blacks and whites, but for rural blacks the rate is 64 percent higher than that for their white neighbors; and while rural areas are frequently viewed as being blessed with clean air, occupational hazards such as black lung disease and allergies to dust and fertilizer all contribute to high rates of respiratory problems among rural adults. Also, 45 percent of the nation's poor live in the thirteen state southern region. Most live in the rural South and nearly one-half are black. Access to medical care in this nation depends upon one's ability to pay for it and upon the availability of adequate health resources. This means that our medical care system is biased against the rural South.

We recognize that economic development in the rural South is intimately related to the development of an effective health care delivery system. Therefore, it is important that a national policy provide a systematic approach which addresses the uniqueness of health care problems in the rural South. This policy should encourage and stimulate the development of innovative approaches responsive to the special needs of rural areas.

These are the highlights of the recommendations from the Southern Rural Health Conference attended by 275 people including rural health experts, members of health agencies, educators, legislators, doctors, primary health practitioners, and concerned citizens.

I was struck by the fact that almost every task group, regardless of its topic, was concerned with the failure of Medicare, Medicaid and other insurance policies to pay adequately for services performed by nurse practitioners, physician assistants, and other primary health practitioners in the absence of the supervising physician. This issue is critical to the survival of innovative delivery programs in the rural South.

Specifically, the conference recommends that Medicare, Medicaid, private health insurance policies and a national health insurance program, if implemented, should cover primary health center services. Eligible providers should include all nonprofit ambulatory health centers providing primary health services and staffed by primary care physicians and/or primary health practitioners employed on a reasonable salary basis. Reimbursement should be on a reasonable cost basis, not fee-for-service, with minimum productivity standards based on maturity and location of center.

Primary health practitioners include nurse practitioners, physician assistants, MEDEX, nurse midwives, dental auxillaries, and other practitioners providing patient care in accordance with state laws.

This is an immediate issue, which I see as part of a larger issue - the need for major system-wide changes in the financing and delivery of health care in rural areas.

The conference recognizes that the first order of business in initiating these system-wide changes is the implementation of universal, comprehensive, national health insurance designed to promote the delivery of primary health services in rural areas. National health insurance should make aggressive use of the reimbursement system to achieve this goal. It is imperative that sufficient national health insurance revenues be targeted toward the development of health and medical resources geared to the special needs of rural people in the South. This should include financial support for environmental health services, nutrition, health education, outreach, and other supportive health activities. Only if health resources development is tied directly to national health insurance, can rural residents be assured of their share of all national health insurance benefits.

We have dealt with a wide range of issues concerned with health care delivery services. One of the most important of these is the effort of student organizations and medical schools to help communities to organize to deal with local health care needs.

The conference has recommended that group practices be reimbursed by public programs for broader services not covered in medical fee schedules. It also recommended ending inequities in rural and urban areas by equalizing payments for services under public financing programs.

We recommend that local medical societies may review and comment on rural health programs proposals, but that they should not be permitted to block the placement of these programs. It is also suggested that established medical providers such as county health departments should be encouraged to share resources and responsibilities with local non-profit providers who have the capacity to deliver these services.

Health care rather than medical care alone is necessary to meaningfully change the health status of the rural poor. We recognize that preventive and household services are essential components of primary health care delivery. In addition, we recommend that these activities be incorporated into primary health care center programs, and be covered by Medicaid and Medicare

We wish to stress that Health Systems Agencies should receive appropriations commensurate with the authorized level of funding. HSA board members should also be accountable and responsive to all racial and economic groups in the health service area.

The conference points out the value of community input and developed several recommendations involving preceptorship programs in off-site community settings. It was recommended that federal funding be made available

to provide incentives and support for these activities.

The task of addressing a diversity of licensing procedures and requirements among various states is a difficult one. It was the recommendation of this group that each state clarify the legal status and responsibilities of primary health practitioners.

This conference has addressed the issue of minority and women's health concerns and discussed discrimination by many rural providers. It also recognized the need for more strict enforcement of the laws against discrimination in health care delivery and that although enrollment of blacks in medical schools had increased prior to 1974, the present trend is a decrease in black enrollment. This group also recognized the need for special programs specifically designed to recruit more women and minorities in all aspects of health delivery. These needs must be met or it may be difficult to recruit medical professionals to meet health needs of minorities in certain areas of the South.

Last night the conferees began the important process of translating the concerns expressed here into action. Participants met in state caucuses to discuss strategies for working together to monitor the implementation of federal and state laws as they affect rural health needs and for influencing, from the grass roots level, the shape of our rural health system.

On the national level, the National Rural Center in cooperation with other rural organizations in Washington will monitor federal actions - laws, regulations, and the performance of federal agencies - to insure that they meet the needs thay are supposed to serve. The National Rural Center stands ready to provide assistance and critical information to the state and community groups represented here and other such groups.

In this summary, I have tried to highlight some of the major themes discussed at this conference. In the past two days we have taken full advantage of the opportunity to articulate and consider major rural health needs and problems. You have proposed, in your recommendations, realistic and necessary goals, possible of achievement, and conveying with them a sense of humanity and concern which should not be ignored.

HEALTH CARE AND RURAL DEVELOPMENT

Dr. Ray Marshall

Once the Task Force on Southern Rural Development (TFSRD) got underway, we recognized that health was one of the most important concerns of rural people. Because health is so intimately related to the process of rural development and because no one had previously made the kinds of investigations we needed, it became clear that a major project on rural health would be required before the work of the Task Force could be completed.

As a consequence, we applied to and received a grant from the Robert Wood Johnson Foundation for a project to look at the rural health problems of the South. In this study, the three questions of major concern studied were:

1. What are the South's rural health problems?
2. What is being done about these problems?
3. What should be done about these problems?

The part of our study I would like to report to you deals with (1) the relationship between health and rural development, and (2) the obstacles involved in developing health delivery systems in rural areas.

The study covers the eleven states of the Confederacy plus Kentucky and Oklahoma. In using this definition of the South, however, it must be realized that there is more to identifying the South than just that broad area. Since one model will not fit the whole South, we must look at the various subdivisions of the region. There is a significant difference between the Appalachian South, the Southwest, and the black belt, for example, and health care delivery systems must be geared to the realities of each area.

A general definition of health is employed which recognizes that health is not solely concerned with medical care but with health in a broader context. This broader context encompasses environmental and preventive health care, nutrition, physical and mental well-being, as well as medical care.

Relationship Between Health and Rural Development

There are several important relationships between rural development and health care. In the South as in the rest of the country, it is difficult to have a productive population if people have serious physical or mental health problems. What often is attributed to apathy among rural people would, in many cases, more properly be attributed to poor health. Clearly, if we are going to have a productive people, we must first recognize and deal with their health problems.

Secondly, the health systems promote development in a number of

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ways. The expenditure of money to establish health facilities makes it possible to improve the quality of life and not just the delivery of health care. Improvement in the quality of life is, in fact, our definition of "development". In addition, one of the most important problems in rural development is leadership. The establishment of a health system draws to the area leaders and health professionals and if the right kind of leadership comes in with the health system, community leadership resources can be augmented. The interrelationships are such that once a community learns to deal with health problems, it almost invariably improves its ability to deal with other problems.

Once a health facility is established, other kinds of economic development can be stimulated, if strategically planned. Although this will not happen automatically, it is clear that the availability of health care is an important inducement for industry to locate in that area.

These relationships between health and development also work in reverse. A community is not likely to be able to develop an effective health care delivery system, or be able to pay for the delivery of medical care, without broader community and economic development. Although national health insurance might help to resolve this situation, health insurance alone will not achieve the desired results.

As mentioned previously, "development" is defined to include activities which combine to improve the quality of life. Health is one very important component of development, but other important components include education, employment, income maintenance, housing, anti-discrimination programs and the development of organizations to deal with the problems of rural development.

Rural Development and National Problems

It is extremely important to emphasize that there is no necessary conflict between rural and urban development. There are some important differences, but the similarities between the problems of the poor in the rural South and the poor of the central cities in the North are very striking.

For example, the incidence of poverty and the behavior of the poverty indexes tend to be very similar between nonmetropolitan areas in the South and central cities outside the South. This should not be surprising since we are essentially talking about the same people.

Poverty has decreased in many areas of the rural South because the poor have moved to central cities outside of the South. We have therefore transferred the problem from the rural South to urban areas, North and South. The significance of this is that very few of those people were prepared by either education or experience for urban life.

Between 1950 and 1970, there was a decline of 2.7 million people from agriculture in the rural South. Eighty percent of the black males who left Southern agriculture had less than seven years of education and fifty-two percent had less than four years of education. It is obviously very difficult to succeed in an urban setting with that amount of education.

It is interesting to note that every significant commission which dealt with urban problems during the 1960's recommended rural development as a way to deal with urban problems. Most of the legislation introduced in the Congress during this period to deal with rural problems was introduced by urban Congressmen, who say rural development is one way of reducing the severity of urban problems. This relationship is especially significant in light of the tendency for so many people to set up a dichotomy between rural and urban areas. Some people argue, for example, that there is little need to deal with rural problems because urban problems are so much worse. The obvious inaccuracy of that belief is seen once the intimate relationship of the problems is recognized. That is, rural development can help to solve many urban problems. On the other hand, in order to deal effectively with many rural problems, we must have effective national policies.

Very little can be done to improve rural health without an effective national health policy. Improved rural development and economic development depend on national growth policy and a commitment on the national level to the development of areas which are not likely to develop on their own, or through the natural market processes.

Similarly, it will be difficult to develop an effective rural transportation policy without a national transportation policy. Thus we recognize that effective national policies are necessary, but not sufficient, for the development of the rural South.

An additional point to consider is the importance of dealing with the unique characteristics of rural areas. Rural areas have many unique features, particularly concerning health, but in other areas as well. Unfortunately too often policies are made by people with urban conditions in mind. Trying to apply such programs to rural people results in a misfit. This is true in health, employment, and is particularly true in programs dealing with poverty.

Rural poverty is not like urban poverty. Most rural poor families are headed by men, while most urban poor families are headed by women. Most of the rural poor families are headed by people who are working either full or part time, while most of the urban poor families are not working. Therefore, the strategy to deal with poverty must relate to the particular problems involved in that particular sector. There are many things that can be learned about urban health problems by studying rural problems and vice-versa. By studying their contrasts, we are able to gain insight into the problems of each sector.

Population, Employment and Income

To set the framework for a statement about development and health, it is helpful to look at some of the trends at work in the rural South.

Perhaps the most important trend in the rural South has been the displacement of people from agriculture. Although this trend has moderated, it has continued and remains one of the most significant factors in rural development. The agriculture population has been reduced in recent years to a relatively small number, thus moderating the

trend. In addition, it should be noted that blacks have been displaced from the rural South at a much faster rate than whites.

However, one of the most important developments in this century has been the reversal in population migration between rural and urban areas since 1970. The rural population of the South and of the nation has been increasing, relatively and absolutely since 1970, after previously declining absolutely. In spite of this, the black population continues to experience a net migration outward while the white population increases in rural farming areas.

Another important trend in rural areas is that manufacturing employment is growing faster than in urban areas. The significant aspect of that growth is that it is extremely uneven geographically.

Of the areas that have declined since 1970, the only one that had grown prior to that time is military installations. Areas with a heavy black population and areas with a heavy agriculture population have continued to decline. There is an almost perfect inverse relationship between areas in the South where blacks live and areas where rapid economic development is taking place. This same indirect relationship exists between areas of heavy agricultural concentrations and areas of economic development. This is meaningful because in order to deal with the development probems of the rural South, we must identify and be primarily concerned not with those growth areas but with areas that are not growing.

Incidence of Poverty in the South

Rural poverty has not declined since 1969. In fact, in 1976 the total number of people in poverty increased. This trend can be directly attributed to the high incidence of both unemployment and inflation each of which tends to increase poverty.

Furthermore, the income gap between the South and the rest of the country is primarily a rural phenomenon. The urban income gap has been closed in real terms, while the rural income gap continues to be fairly large at about 10 percentage points. It is significant that the South-non South income gap that has existed since at least 1840 has almost converged with respect to metropolitan people, but not with respect to rural people. While poverty in the South is mainly a rural or non-metropolitan phenomenon, poverty outside the South is mainly a metropolitan phenomenon.

Additionally, in 1975 in the nonmetropolitan South, only 15% of whites, but 44% of blacks were below the poverty line. It is true, however, that most of the poor in the rural South are white. There are now 10.5 million poor people in the South--6 million are white, 4.5 million are black.

Health and Nutrition

There are several significant factors that make health problems of the rural South different from both the urban South and the rest of the

country. The first of these factors is poverty which is much more serious in rural areas and which reduces the ability to pay for health care.

Secondly, it is difficult to separate the serious transportation problem in the rural South from the health problem, especially when thinking of emergency health care and the accessibility of primary health care.

A third factor that contributes to the special nature of health problems in the rural South is poor communications. This is true both in terms of the people's unwillingness to communicate with the health system, and the system's inability to reach the people.

Fourthly, there are much more limited medical and health services in rural areas than in urban areas. This is particularly true of preventive services and services for children. A very important health problem is the unavailability of dental care. In fact, in many ways, the dental problem in the rural South is worse than the medical problem and is more directly related to health than many people assume.

Another difference between the rural South and other areas is the environmental factor. The availability of sewage facilities, clean water and housing are very limited in some rural areas. There are very severe occupational health problems in some of these areas. This is particularly true of coal mining, for example, which is mainly a rural industry. It is also true of agriculture. Although agriculture tends to be one of the most hazardous industries, very few of the Southern states make provisions to compensate agricultural accident victims.

Finally, the unavailability of employment and recreational opportunities have an important impact on the emotional health of people in the rural South. Depression is a significant problem in some rural areas.

In general, in the rural South, we see a much higher incidence of health problems, infant mortality, general mortality, and instances of particular diseases.

Obstacles in Developing Health Delivery Systems

The main obstacles to improving the health care of people in the rural South can be organized under several main categories.

First, all rural people, not only the low income, have inadequate coverage of public and private health insurance. Both Medicaid and Medicare are biased against rural areas. They do not do as much for rural people as for urban people.

Another serious obstacle to improving health care is the nature of rural medical practice. The attraction of health professionals has always been one of the most serious problems for rural areas.

The reasons for this are fairly clear. Perhaps the most obvious of these is professional isolation. Along with this is the instability

of the rural practice, where it is based on the solo practice model. And, finally, but certainly as important, is that rural physicians, although their earnings compare favorably with their urban counterparts, work harder and have less time off for either professional or recreational purposes.

A third obstacle is that the medical system is biased against rural areas. This is true for a number of reasons. One of the systems imposed values is specialization. This trend has caused a decline in the relative proportion of health professionals located in rural areas. Although specialization has long been one of the primary values of the system, it continues to be very difficult for a physician to specialize in rural areas with scattered populations.

The use of sophisticated medical technology and the training of medical students to practice with that sophisticated technology add to the reluctance of physicians to go to rural areas. They realize that the technological resources they depend on will not be available.

Another major obstacle to improving health care for people in the rural South is the limitation on the use of non-physician health professionals. It has been demonstrated that physician extenders can be used to deliver quality medical care to isolated rural people. There are, however, considerable biases in the system against using non-physician health professionals. These biases are likely to grow as the supply of physicians increases.

These systemic problems require that we develop a new kind of system in order to deal with rural health problems.

One final impediment faced by the rural South is racial or ethnic discrimination and an insensitivity of many medical professionals to the problems of particular racial or ethnic groups. Obvious and overt discrimination against people because of their race or language is prevalent on a surprisingly large scale in the medical system. Probably more important, and obviously related, is institutionalized discrimination. That is seen simply as an insensitivity or unwillingness to take affirmative action. It is not sufficient to simply say that minority groups are welcome to use the available facilities. Nondiscrimination must be made a reality in order to evoke a change. One way to make that change is to increase the number of minority physicians and other health professionals, but instead, the number of minority physicians is decreasing.

INNOVATIVE APPROACHES TO THE DELIVERY OF PRIMARY HEALTH SERVICES IN THE RURAL SOUTH

Dr. Karen Davis

Our study of rural health care conducted for the Task Force on Southern Rural Development singled out the delivery of primary health care services for special analysis. Since very little systematic information on this aspect of health care was available, we carried out extensive field work in this portion of our study, visiting over 50 innovative primary health care projects of a wide variety of approaches.

The field work on primary care delivery was guided by two concerns. First, we wanted to identify successful approaches to the delivery of primary health care services and to analyze those factors which enabled them to overcome many of the genuine obstacles which prevent improvement in rural health care. By identifying successful approaches and identifying ways in which to promote the delivery of quality health care in rural areas, we hoped to dispel the myth that nothing can be done about the problems of the rural South.

Second, the emphasis on primary care seemed warranted because of its key role in improving health, promoting rural development, and fostering longterm reductions in the total cost of health care. Primary health care is typically the most deficient type of care in rural communities. In the case of a life-threatening emergency, rural people do seek out care, sometimes at considerable time delay, unnecessary morbidity and mortality, and high cost. Better primary and preventive health services have the potential to improve the overall level of health and at the same time lower costs in the long-run by eliminating the extent of serious hospitalization.

Prior to selecting primary health care projects for site visits, we compiled a catalog of approximately 200 innovative rural health care projects. A sample of projects was selected representing a wide variety of approaches to primary health services delivery as well as geographical areas. Of all the projects we visited, three basic approaches to primary health care seemed very successful--primary health centers, group health practices, and comprehensive health centers. Each of these approaches seemed to work best in different kinds of rural communities.

Primary Health Centers

The primary health centers tend to work well in small rural places which cannot economically support a physician or are otherwise not attractive to physicians as practice locations. Many of these health centers are located in towns with populations of from 500-1000 people and may serve an outlying area of 2000-3000 people. They are typically

small-scale organizations staffed by one or two primary health practitioners. This term includes nurse practitioners, physician assistants, *medex, nurse mid-wives,* and a number of other non-physician health professionals who are increasingly taking on tasks traditionally performed by the primary physician. These centers usually arrange for part-time services of a physician (usually one day per week) who is also available for telephone consultation throughout the week. In addition, the primary health centers may have one receptionist who doubles as a laboratory technician.

It is also important to note that the primary health centers which we identified tended to be located in those states where the state laws were conducive to primary health practitioner practice, where state governments or health departments encouraged their growth, or where Medicaid reimbursement was supportive.

While these are common characteristics of all sites which we visited, there were some variations. Clinics varied in terms of types of facilities- including fixed housing, trailers, and mobile vans. Some projects were free-standing clinics while others were satellites of other projects including group practices or comprehensive health centers. In instances, clinics banded together to share physician services. Variation also occurred according to the source of physician supervision and input. Some clinics contract with private practicing physicians in nearby larger towns. Others are served by medical school faculty on a part-time basis. The National Health Service Corps sometimes provides a physician serving one or more clinics. Some clinics employ a physician on a full-time basis.

This model appears to have very strong economic advantages. Of all the models which we visited, it had the lowest cost of providing primary health services. The total expenses of operating the clinics including the services of two primary health practitioners and other support staff run from $50,000 to $100,000 per year, with an average annual operating expense of $60,000. The start-up costs ranged from almost nothing to around $60,000. Many clinics were successful in getting donations of land and space, and in obtaining community-donated labor and materials. Therefore, construction and renovation of facilities were accomplished fairly cheaply. Others were able to make use of Sears and Roebuck facilities which were constructed some time ago.

The daily patient load in these clinics averaged from 10 to 25 patients per day. Most averaged seeing 22 patients per day or 5000 to 6000 patients annually. The national average for primary health physicians is approximately 5000 patients annually. Therefore, these clinics are seeing a patient load equivalent to that of primary care physicians.

Most of the primary health centers do charge fees with the exception of the Georgia Health Access Stations which use public health nurses and are funded by the state health department. These fees vary for a routine office visit from $4 to $8 in addition to laboratory tests or other kinds of services. The costs on a per patient basis average from $10 to $12 per visit. If the clinics were successful in collecting their full fees most of them could break even. However, many of these

clinics are in very poor areas and fees are frequently waived or reduced. Patient revenues in a few of the clinics are now breaking even particularly as patient loads have increased and practices have built up. Most of the models which we visited were averaging revenues from $20,000 to $30,000 and were operating in the red during the first year or two in their existence. They were subsidized by state funds, by the Appalachian Regional Commission, by private foundations, or indirectly through National Health Service Corps staffing.

Reimbursement is a great problem in these clinics since many of the patients are poor and are not covered by Medicaid. Seventy percent of the rural poor have both parents in the home and do not qualify for Aid to Families with Dependent Children or Medicaid. Unless there is some basic reform in the Medicaid program in terms of a movement towards National Health Insurance, many of the poor will not be covered for medical and health care. Many states will not pay for the services of primary health practitioners even for patients covered by Medicaid. In other instances, Medicaid payments for their services go to the sponsoring physicians instead of going directly to the primary health centers. Sometimes Medicaid fees are at a below-cost rate, such as $4 or $6 per visit. Medicare will not pay for the services of the primary health practitioner unless a physician is present at the time the health service is rendered.

One strong advantage of the primary health center is its record in recruitment and retention of health personnel. It is difficult to get physicians to many small rural areas and to keep them there once they are located. Many of the sites which we visited had excellent records with regard to recruitment and retention due to the practice of hiring local people who were trained in nurse practitioner and physician assistant programs near the area. These people had a high rate of returning to these communities and remaining there. One factor behind this phenomenon seems to be that their families were already located in the community and they looked upon it as a permanent site.

We surveyed a number of quality studies that have been conducted and found that the care rendered in primary health centers ranked equal to or better than the quality of care rendered by primary physicians. However, we did see the need to have some provision which would insure the quality of care through training requirements, continuing education, and continuous monitoring and auditing of performance by supervising physician. We also recommended that physicians be available for backup and referral and that state medical and nurse practice acts be amended to determine what kinds of services primary health practitioners may perform and in which settings. The State of North Carolina has developed the most careful guidelines for the practice of nurse practitioners and physician assistants.

We identified a very strong need for technical assistance in these clinics. It was particularly surprising to come across projects which did not know the existence of a similar project in the same county. In these cases, they were struggling with many of the same problems but were not aware of parallel efforts of others in neighboring communities. One of the objectives which we hope that this conference will accomplish is

to promote the establishment of networks which will enable local people who are trying to start a project to benefit from the experience of others in their state. I also see great merit in publishing a directory of all rural health centers to facilitate mutual contacts and information sharing concerning funding from federal sources and other kinds of assistance.

Another advantage of the primary health center is the aspect of strong community involvement. Many centers were acting to promote community development generally by developing leaders within the community and expanding into other activities. Once they had learned how to confront the local county commissioners to get local revenue sharing funds, they were also able to organize for additional needs such as paving the roads. There is a major need to provide development funds and opportunities for more local people to become involved in these practices.

This model is promising but its future is uncertain. It is possible that the demands on these primary health practitioners may get very heavy as they have on isolated general practicing physicians, but this is less likely to be a problem in clinics which have more than one primary health practitioner. Continued professional development will require specific efforts for continuing education. There is also the problem of after-hours coverage since many primary health practitioners prefer not to be available at night. This necessitates some provision for backup during hours when the clinic is closed. The major problem facing primary health centers, however, is obtaining adequate compensation from Medicare, Medicaid, and private health insurance plans.

Group Health Practices

Another model which we studied extensively was the group health practice. These tend to be established in much larger towns with populations of from 6,000 to 20,000 people. The basic practice model is comprised of two or more primary care physicians working in a team with nurse practitioners or physician assistants. Some of these projects also include dentists, dental auxiliaries, lab services, and emergency care facilities. Most of these larger health centers have professional managers who are a very important part of the overall team. The intention of this model is to attract health professionals who want to live in rural areas and thereby form permanent practices.

Again, this model has a number of variations. Some projects are non-profit group health practices with community boards such as the East Kentucky Health Services Center in Hindman, Kentucky. This particular project which is funded by the Robert Wood Johnson Foundation, is characterized by a strong leadership team of 5 primary care physicians and good administrative management. Any surplus is plowed back into community services including screening, environmental health, and other productive community efforts. The Robert Wood Johnson Foundation is now funding a major demonstration program to test this approach in a wide variety of rural settings throughout the nation.

We also visited some for-profit clinics such as the Morehead Clinic in Morehead, Kentucky. Although these tend to be more traditional medical practices, some are trying innovative aspects like the use of

primary health practitioners in a team approach, satellite clinics, and professional managers.

The federal government has also funded some major programs in group health practice through Rural Health Initiatives and Health in Underserved Rural Areas Projects administered by the Bureau of Community Health Services and the National Health Service Corps. Most of these projects are staffed by National Health Service Corps physicians.

Another group practice model is the Health Maintenance Organization. Although there are not many HMO's in the South, we were able to visit Mountain Trails in Harlan, Kentucky and Su Clinica in Harlingen, Texas, which have HMO components. We also visited a number of family health centers which have patients paying both on a fee-for-service basis and some on a capitation basis.

There are several variations on the group health model but they all have the common element of providing health services through a group of primary care physicians working as a team. This particular characteristic of the practice seems to be very appealing to physicians in overcoming many obstacles such as long hours, heavy demands upon time, and professional isolation. Support services from laboratories and relationships with other health resources appear excellent in the group approach. It also provides physicians and other health professionals with time off for continuing education.

Studies have found that rural areas are sometimes not attractive to physicians because spouses feel isolated and do not find these areas to be culturally attractive. We observed that in some group practice situations, members of the practice and their families tended to form their own social units and found it quite palatable. In some practices, husband-wife professional teams were active in the practice.

The administrator is a very important part of this model in that a good professional manager can make a practice financially viable even in relatively low income areas. Some practices were running total budgets from $300,000 to $400,000 and after a three year period were breaking even through efforts of very aggressive managers who had gotten contracts for Headstart, Black Lung screening, county health department, or Medicaid services.

The use of the primary health practitioner in this team model does receive physicians of the burden of heavy patient loads. Since they are also less costly personnel, they contribute further to the economic viability of the clinic.

This model poses some concern over the long run. There may be some neglect of less profitable services in these practices because of the strong emphasis upon economic self-sufficiency. In stressing physician care, group health practices may also take a narrower medical approach and be less inclined to do outreach and non-medical kinds of services. An additional concern which we have is that these practices will exclude very poor people who are unable to pay the rate of fees which are assessed.

The National Health Service Corps also has some inherent weaknesses as a long-run solution to rural health problems. The Corps has been very flexible in supplying physicians and other health personnel to a variety of models including group health practices. Many rural places which could never have afforded a physician have benefitted greatly from Corps support. We visited a number of model NHSC placement sites, and were somewhat concerned over the high incidence of turnover of physicians placed by the Corps in rural areas. Nationally, only 13 percent of Corps personnel remain in private practice in the area to which they are assigned. The communities are often resentful of the attitudes of physicians who are there only on temporary assignment. We also heard complaints concerning failure of physicians to wear white coats, disapproval of housing arrangements, and the overall failure of physicians to mesh with community values. Physicians who might have moved there to establish permanent practices probably would have behaved in a different manner than those who did not intend to stay.

The Corps has put great emphasis upon economic self sufficiency and has urged practices to collect fees. We found that in one project we visited, the poor people did not go the the Corps clinic because they could not afford the fees. Instead they had to travel 30 miles away to a county health department, where the Corps physicians worked on their off day. Thus, they were being seen by the same personnel but because of economics, they could not be seen at the Corps practice.

Community involvement tends to be very limited in these projects. Typically the county commissioners will support the practice but there is little chance for community individuals to play a role in the clinics.

Comprehensive Health Centers

The final delivery model which I would like to discuss is the comprehensive health center. Of all the centers which we visited, it is the largest. Budgets run from $1 million to $3 million per year and are much larger than either the primary health center or the group health practice. In spite of their great costs, these centers seem to be very desirable in those areas with deeply entrenched health problems and high rates of poverty. We found in those service areas a high incidence of mental, environmental, and nutritional health problems in addition to housing deficiencies, lack of jobs, and need for rural development. Since many people in these areas have limited education, they are not likely to make use of a physician because they do not understand the health care system and are unsophisticated about health care in general. All the comprehensive health center projects which we visited provided a wide range of health care services in addition to medical care including dental care, prescription drugs, nutrition, environmental health, patient education, transportation, and child development among others.

Such a broad approach can be extremely important in contributing directly to rural development as a provider of jobs and indirectly as a stimulator of other activities. For example, two of the comprehensive health centers we visited were successful in getting outside grant support for water and sewer demonstration projects. In addition, these

centers had trained an impressive array of local people to work in the projects. We were struck by the success of these centers in providing opportunities for community people to develop managerial skills and political leadership. Without the influence of these programs, such opportunities would not exist. We found a tremendous upgrading of skills at all levels in these centers. For example, in one clinic, an illiterate person was trained as a lab technician. Others without high school degrees who were employees of the project were encouraged to pass high school diploma equivalency tests and were then trained as RN's, LPN's and even Family Nurse Practitioners.

Many of these comprehensive health centers overcame tremendous racial opposition. One has only to look back at pre-health center days when discrimination was prevalent in the form of segregated waiting rooms, housing, and employment practices. In one case, the county judge would not sign a waiver to let the health center exist. Pro-center forces ran an opposition candidate in his district which was sixty percent black. The judge chose to make a deal and not only signed the waiver, but also paved the road to the clinic. Therefore, these projects through the backing of the federal government and assistance of funds have been very potent forces for social, political, and economic change in the advancement of minorities.

These projects have also succeeded in reducing infant mortality rates, serious illness, and serious hospitalization. A national study of patients treated by comprehensive health centers has revealed that hospitalization has been reduced by from 30 to 35 percent, which represents an enormous saving in terms of total health care costs. I started this study with a bias that these centers were not very cost effective in total outlay of funds. However, in analyzing the data, I find that this is not the case. Medical costs ran from $20 to $25 per patient visit which is roughly equivalent to rates for the group health practice. Environmental, mental health services, and other non-medical costs add another $15 to $20. Including all costs, the overall total runs about $200 per person per year which is roughly the national average for all people. When combined with the savings resulting from reduced hospitalization, the comprehensive health center is one of the most cost-effective approaches.

The Comprehensive Health Centers have suffered in the last few years from funding cutbacks and the elimination of training funds. Changed directives from HEW have emphasized charging fees, collecting from third-party insurance plans, and treating higher-income patients. This has cause considerable turmoil as centers established with one set of goals in mind have had to accommodate to new emphases. Most centers have found it difficult to make substantial progress toward economic self-sufficiency because they are located in poor rural communities, most patients do not have private health insurance, many rural poor are not covered by Medicaid, and even where covered, Medicaid and Medicare reimbursement policies are not adequate.

Despite the proven success of this approach in improving the health of the rural poor, promoting rural development, and upgrading skills and position of the disadvantaged, this program has not been expanded

in recent years. There are fewer than 20 such centers in all the rural South, a number which is miniscule relative to the areas of severe poverty and entrenched health problems. Expansion of this program to all severely needy communities is strongly warranted.

Recommendation

While a number of innovative approaches to primary health care delivery are being tried in the rural South, it would be misleading to imply that everything is being done which needs to be accomplished. Many of the projects currectly underway may prove to be short-lived without some fundamental changes in governmental financing programs. Most approaches are being tried on a small scale, that falls far short of meeting the total need. For example, the National Health Service Corps has fewer than 500 health professionals in the entire United States, compared with an estimated shortage of 15,000 health professionals in critical health manpower shortage areas. Many discriminatory practices are still prevalent in the rural South, and minorities have few places to turn for decent quality health care. Many current efforts need to be expanded; other actions need to be taken to foster and nurture the growth of current efforts.

In our report to the Task Force on Southern Rural Development, we made a series of recommendations to help promote these innovative approaches to primary health care delivery. These include:

Primary Health Centers

1. Primary practitioner clinics with backup part-time physician support should be organized within smaller communites which cannot support or attract groups of physicians. Such clinics should be sponsored by stable, ongoing groups. Greater financial support should be provided by federal, state, and/or local governments to the development of these types of clinics in small rural places.

2. The National Health Service Corps should continue to experiment with a greater variety of approaches to rural health including more emphasis on primary practitioner clinics, and other rural models.

3. Medicare, Medicaid, private health insurance, and national health insurance, if implemented, should reimburse for services of primary health practitioners when provided in community-sponsored, nonprofit rural health centers meeting specified standards. Payment should be made directly to the health centers as providers of health services. Physical presence of a physician should not be a requirement for reimbursement. Reimbursement should be on a reasonable cost basis, or on a capitation rate equal to expenditures incurred by comparable beneficiaries on a state-wide or nation-wide basis.

4. Medicaid should be revised to cover all low-income families regardless of welfare or employment status, or should be promptly replaced by universal, comprehensive national health insurance.

5. Greater support should be given to the development of broadly-trained non-physician health professionals. Training nurse practitioners and physician assistants in local areas or through Area Health Education Centers would enable many rural residents to be trained for more responsible roles in providing health services to their own communities.

6. Legal support and technical assistance should be given to promote the effective use of primary practitioners. State Nurse Practice Acts and Medical Practice Acts should be amended to permit nurse practitioners with appropriate training to treat patients and write prescriptions subject to requirements on physician backup and supervision, written protocols, continuous auditing of nurse practitioner performance and continuing education. Such nurse practitioners should be permitted to see patients without the physical presence of a physician, if the backup physician is available by telephone for consultation and such physician participates in a continuous auditing of primary practitioner performance.

7. Support should be provided to summer student health programs such as the Vanderbilt Student Health Coalition. These programs can form the catalyst for community organizing activities leading to the establishment of permanent primary health centers.

Group Health Practices

1. States should support the establishment of family practice residencies in rural areas.

2. Group practice should be established where needed to prevent social, cultural, and professional isolation and overwork. Programs should be adopted to help meet the start-up costs of establishing rural group practices, if these practices meet certain conditions required for effective rural health care delivery.

3. Provisions should be made for the continuing education of the health professionals involved in rural practice. This could be done by planning for periodic attendance at conferences, short courses, seminars held within the area, or interaction with members of the faculty on medical school staffs.

4. Special attention should be given to the establishment of management systems for health centers. As a number of such systems are available, each should be studied very carefully to develop a model for particular practices. Moreover, a skilled administrator should be made an integral part of every rural health practice.

5. Medicare, Medicaid, private health insurance and national health insurance, if implemented, should establish reimbursement fee schedules for physicians that reward rather than penalize physicians for practicing in underserved areas. Equalizing reimbursement rates between urban and rural areas is a necessary first step.

6. The National Health Service Corps should continue to experiment

with a greater variety of approaches to rural health including group practices, and better technical assistance to Corps practices.

Comprehensive Health Centers

1. Rural health practices should be concerned with environmental health and preventive medicine. Because of the conflict within practices between their primary concern for providing medical care and attention to environmental health problems and community affairs, private medical professionals may or may not provide the leadership for environmental health and preventive medicine. Therefore,

a. Non-profit corporations should be established with community representation on boards of directors to create concern with environmental health problems within medical practices.

b. Community outreach programs and transportation facilities improve the access of rural people to medical care but these services increase the cost of providing health care. The social benefits of such services, however, justify social assumption of some of these increased costs for rural communities with deeply entrenched health problems.

2. Special attention should be given to meeting the dental care and mental health needs of rural people.

3. Rural areas have a much higher proportion of elderly people, and the incidence of chronic conditions and confinement to bed is much greater in the rural South than other areas. Therefore, emphasis should be placed on home health services for qualified nursing care to the rural, homebound elderly.

4. Because of low educational levels, many rural residents are unfamiliar with good health habits. Effective patient health education, supplemented with visual aids where appropriate, should be a part of rural health care.

5. Since preventive care has long been neglected in rural areas, special emphasis should be given to well-baby care, immunizations, contraceptive information, cancer screening, and prenatal services.

6. National health insurance should include funds for development of supplemental programs to overcome specific barriers to improved health in poor rural areas. Ameliorative programs would include transportation services, outreach services, and patient education services.

7. Medicare, Medicaid, private health insurance plans, and national health insurance, if implemented, should permit comprehensive health centers to receive capitation payments based upon average cost levels for all persons covered under these programs on a statewide or nation-wide basis.

8. Comprehensive health centers currently funded by the U.S. Department of Health, Education, and Welfare should be maintained rather than cut back as they have in recent years.

CONFERENCE TASK FORCE RECOMMENDATIONS

A major portion of the Southern Rural Health Conference was devoted to the discussion of selected rural health issues in small discussion groups. The major recommendations of each task force are listed in the following section. These proposals are a result of discussion and deliberation by group members, but are not meant to be an all inclusive blueprint for change. They are the products of thoughtful interchange among experienced and knowledgeable people and represent some positive directions for health policy change.

UTILIZATION OF PRIMARY HEALTH PRACTITIONERS

Task Group Leaders:

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Mrs. Rose Littlejohn
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1. Effort should be undertaken to standardize licensure and procedures of practice for the primary health practitioner (nurse practitioners and physicians assistants) among all states of the region. Standardization should be accomplished by professional agreement or concensus rather than mandated by legislation.

2. Medicaid, Medicare, private health insurance, and national health insurance (if implemented) should cover primary health center services. Eligible providers should include all non-profit ambulatory health centers providing primary health services and staffed by primary health physicians and/or primary health practitioners employed on a reasonable salary basis. Reimbursement should be on a reasonable cost basis not fee-for-service, with a minimum productivity standard based upon maturity and location of centers. Primary health practitioners include nurse practitioners, physician assistants, MEDEX, nurse midwives, and other providers providing primary care in accordance with state laws.

3. Considerable effort should be expended to inform professional and patient communities of the role and function of the primary health practitioner. The existing health structures must be encouraged to fully utilize the primary health practitioners and formal linkages should be established between the primary practitioners and health departments, hospitals, and private providers.

GROUP PRACTICE IN RURAL AREAS

Task Group Leaders:

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1. In order to strengthen the incentives for health professionals to locate in rural areas, we recommend ending inequities between urban and rural areas by equalizing the reimbursement rates for medical services under public programs.

2. Primary health practitioners should be reimbursed by Medicare and Medicaid for those services which they are permitted to render by state law.

3. In order to encourage the delivery of better services by group practices, those practices should be reimbursed under public programs for broader services than those included in the medical fee schedules.

4. In order to strengthen the delivery of preventive rural health services, we endorse the concept of federal grants to states to be distributed to organizations and agencies in rural areas which are most capable of delivering those services.

5. We recommend a national assessment of the role of county health departments.

STUDENT ORGANIZATIONS AND MEDICAL SCHOOL RURAL HEALTH ACTIVITIES

Task Group Leaders:

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1. Student organizations and medical school rural health activities should be based upon accomplishing the following objectives:

   a. To help communities to deal with their own needs.

   b. To influence students to return to a rural area after the completion of their training.

   c. To promote on the part of students an understanding of rural life and the viewpoint of rural people.

   d. To teach students to interrelate with practitioners of other disciplines.

   e. To help students to learn to relate to community people and to community leadership.

   f. To motivate students to participate in student run projects and to motivate schools to support them.

g. To orient students to primary care.

h. To render services to the community including community health education and to render that sort of service which will help communities achieve self-reliance.

i. To provide clinical education for the student.

j. To broaden the interdisciplinary base of the project by including students from many fields.

k. To teach students about the total health care delivery system in rural areas.

l. To teach students, practitioners, and community people to redefine their concept of health care toward total care as distinct from medical care alone.

m. To involve student spouses when possible.

2. A wide variety of projects should be made available to students. Activities emphasized should incorporate the greatest number of objectives listed above.

3. The outcome of student projects should be further studied to learn their long-term impact on students, schools, and communities. However, student participants in these projects should not be called upon to carry out these studies.

4. School administrations should be supportive of student projects but should not interfere with their operation.

5. More funding should be made available for projects in areas where it has been inadequate -- particularly the cotton belt, the coastal plains, and the state of Texas.

6. Consumers should have input into the design and administration of student projects. Students should solicit this information from the consumer, and funds should be provided for this activity.

7. Projects should be more interdisciplinary in focus than they are at present. Students should be included from fields such as social work, dentistry, health administration, engineering, and others. Projects should thus be more comprehensive but should not engender dependence by the students on a complete team of workers.

8. A community experience should be a required part of all curricula.

9. Health school admissions policies should be altered to recruit students with a more humanistic attitude. Admissions committees should consider factors other than grade point averages including students' attitude and their history of community activities.

10. Studies should be undertaken to discover methods to help rectify the severe nursing shortage in the rural South. Recruiting of nursing students should become a priority and more funding should be made available for nurse practitioners.

INNOVATIVE GOVERNMENTAL PROGRAMS

Task Group Leaders:

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1. States should be encouraged to amend or alter licensure laws and practice acts to allow for the provision of care by nurse practitioners and physician assistants, whether or not the physician is physically present.

2. Medicare and Medicaid should reimburse for services provided by nurse practitioners and physician assistants whether or not the supervising physician is physically present.

3. Local medical societies should be fully involved in planning for rural health grants (including the National Health Service Corps) and should exercise their proper review and comment functions, but they should not continue to have de facto veto authority.

4. More technical assistance -- both contract and HEW -- should be provided to Rural Health Initiative (RHI) and Health in Underserved Rural Areas (HURA) grantees and regular evaluations should be made to determine the impact of the TA on the success of the project.

5. The existence of rural health programs should be communicated to "target" communities through visits by regional office personnel. Technical assistance should be provided at the pre-application stage in the form of model proposals, budgets, and examples of modes of rural health delivery which may be adopted to their needs.

6. The National Health Service Corps should conduct a more aggressive affirmative action program in training and placing minority health professionals.

7. Rural health centers should be reimbursed by Medicare and Medicaid on a cost-basis.

ENVIRONMENTAL AND PREVENTIVE HEALTH

Task Group Leaders:

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1. Three levels of services were considered in this task group: 1) individual preventive services within the office, 2) family and household oriented preventive services, and 3) community level preventive and environmental services. As a general strategy, it is recommended that services at all three levels should be initiated as primary preventive activities or in response to presenting a clinical problem within the primary care center. Examples of presenting conditions would include: pregnancy, diabetes, obesity, heart disease, toothache, trauma, black lung, poisoning, and arthritis. From these and other clinical conditions specific individual, family and household and community preventive services should be designated for delivery.

2. It is critical to health status impact that preventive and household environmental services be recognized as an essential component of primary health care.

3. Primary health care centers need to include a provider who has the job and is accountable for providing preventive and household environmental services within the primary care center.

4. The primary care center should work to strengthen community health service support systems within the community.

   e.g. - Build strong direct referral mechanisms and,

   - Recognize and utilize existing structures of rural social organizations such as churches and agriculture groups.

5. Protocols and standing orders should be written that will provide standards of care for all three categories of preventive and environmental services.

6. There is a need for legislation in the area of environmental sanitation. For example, whereas one-half of water consumption is used in human waste disposal and water is often limited in a rural setting, it is recommended that sanitary pit privies be reapproved as an appropriate alternative method of human waste disposal in a rural setting.

7. Alternative models of integrating preventive and environmental health services should be studied and compared in terms of their relative effectiveness.

8. Financing alternatives for integrating preventive and environmental services should be explored. For example:

   a. Change Medicaid, Medicare, and categorical reimbursement procedures to pay for preventive services, health education, and household-family oriented preventive services.

   b. Develop cooperative arrangements with local community agencies to share personnel and/or jointly fund preventive health services providers within primary care centers.

   c. Take advantage of technical assistance in preventive and environmental services that are available from local, county, and state agencies.

   d. Develop contracts or capitation funding arrangements with county and state funding agencies.

   e. Health education and preventive and household environmental services should be funded in part by surplus from patient treatment income.

   f. Obtain special project grant from private foundation or state or federal funding agencies.

EDUCATION OF HEALTH PROFESSIONALS IN RURAL AREAS

Task Group Leaders:

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The education of health professionals should include non-clinical experiences in community based settings. Schools of health sciences should make conscious efforts to include community people in the curriculum so that community values and perspectives of medical issues will permeate the educational process. Communities should be encouraged and assisted in developing their own assessment of health care needs and priorities.

2. There is a need to develop a list of the characteristics of successful and unsuccessful off-campus training programs and this information should be widely disseminated.

3. Federal funds, special programs, and reimbursement for services should provide incentives and support for the education of health professionals in off-campus settings both urban and rural. Capitation support for schools of health sciences should have a quid pro quo requiring a set period of off-site education for all students. It is necessary to provide the health professional students prior to their off-campus experience with a thorough grounding and understanding of the area in which they will be receiving their training.

4. Health professional schools should provide for joint clinical rotations to further the interdisciplinary team approach.

5. The leadership role for continuing education for the health professional must be placed at the doorstep of the licensing bodies and they should be responsible for making continuing education both accessible and available.

6. More people from rural areas should be enrolled in health science schools without the institution of any quota systems.

FINANCING OF HEALTH CARE

Task Group Leaders:

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1. The current system of financing and delivering health care in the U. S. fails to meet the needs of rural people. Major system wide change is required. The first order of business is implementation of universal, comprehensive national health insurance designed in such a way as to promote the delivery of primary health services in underserved areas. This plan should cover the entire population and a comprehensive range of benefits - including preventive services, physicians' services, primary health center services, hospital and nursing nome services, mental health services and dental health services for children.

2. Realistically, it is expected that patients will be required to pay a portion of their own bills. It is recommended that any patient payments be kept modest in relation to income, and eliminated or at minimal levels for preventive and primary health services.

3. National health insurance should make aggressive use of the reimbursement system to promote primary health services in rural areas.

a. Physician fee schedules in rural areas should be equal to urban areas.

b. Fee schedules should be increased for primary and ambulatory health services and reduced for specialized and institutional health services.

c. Primary health centers, comprehensive health centers and other non-profit ambulatory health centers should be reimbursed on a reasonable cost basis with minimum productivity standards based on maturity and location of center.

d. Services of primary health practitioners such as nurse practitioners, physician assistants and nurse midwives should be covered when provided in organized systems of care.

4. It is imperative that two percent of all national health insurance revenues should be placed in a health resources development fund to be targeted on creating additional resources in underserved areas. Funds should be used for:

   a. paying for selected additional services in needy areas such as environmental health services, nutrition, child development, patient education and counseling, outreach and transportation;

   b. developmental funds for additional primary health centers in areas of critical health manpower shortage areas; and

   c. training funds for residents of underserved areas to be trained as community health workers and primary health practitioners.

   Only through tying health resources development directly with national health insurance can rural residents be assured of a fair share of all national health insurance benefits.

5. In the past, many governmental health programs have not fit rural realities and have not been administered with an accurate understanding of rural conditions. It is recommended that the possibility of a separate Cabinet level Department of Rural Development be explored. The Department would receive funds from a health resources development fund created in national health insurance. These rural health activities should be coordinated with broader rural development efforts. Rural health projects should have realistic goals, and federal funding should be assured on a continuing, stable basis so long as these goals are being met.

6. One major problem with past governmental programs is their lack of applicability to rural areas. It is recommended that federal and state legislation and regulations be monitored and this information communicated to rural groups so that their views and recommendations can be channeled to the proper decision-makers.

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1. State nurse practice acts and Medicare and Medicaid regulations should be amended to allow for reimbursement of services provided by primary health practitioners when a physician is not physically present. Primary care centers should be reimbursed rather than direct payment to practitioners.

2. Medical societies should not have veto power over the placement of health personnel and funding of federal programs.

3. Migrant workers should have some means of identification that would permit and enable them to receive health care services wherever they might be. They should also have a method of carrying some form of medical history with them to insure better follow-up of their health problems.

4. The state public health laws should be revised to allow for the provision of primary health care.

5. Those health professionals receiving third party reimbursement should be periodically reviewed by the fiscal agency to determine whether discriminatory practices are in effect. If such practices are in effect, disciplinary action should be taken by the fiscal agency.

HEALTH PLANNING AND RESOURCE DEVELOPMENT

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1. The Health Planning and Resource Development Act (93-641) should be amended to allow for geographical re-designation of health service areas where such re-designation would serve to better implement the law.

2. The House and Senate appropriations committees should be encouraged to provide adequate funding to allow the HSA's to perform the functions required of them during conditional designation.

3. Board members of Health Systems Agencies should be publicly accountable to all sectors of the population which they represent including minority groups.

4. In states where wide geographical areas are covered by an HSA, adequate funding should be provided to establish sub-area councils so that staff time and governing body time will be kept to a minimum with regard to travel.

5. HSA's should pay particular attention to the utilization and coordination of existing resources in their area.

6. The group recommends that each Health Systems Agency develop a means of insuring accountability of board members to the public before the full designation of HSA's in 1977.

LEGAL IMPLICATIONS AND PROBLEMS

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1. Each state must act to remove the obstacles to the delivery of primary care by primary health practitioners through a clarification of state laws regarding the practice and licensure of these providers. Each state should determine the permissible limits on practice by the primary health practitioners including:

   a. The extent of physician supervision.

   b. Documentation and records.

   c. Distance between the primary health practitioner and the physician and the frequency of consultation between these providers.

   d. Prescription of drugs to patients.

   e. Administration of injections, IUD's, etc.

   These questions should be dealt with on a state basis rather than by the federal government

2. Attention should be given in each Health Service Area to insure that rural health interests are included in each Health Service Plan and each Annual Implementation Plan.

3. Discrimination against National Health Service Corps applicants should be dealt with by legal action. Discrimination through failure to accept Medicaid and Medicare assignments should also be subject to legal action.

4. Medicare and Medicaid should set fees based upon a statewide profile. Fees should be paid directly to the health center for all services performed by a legally authorized provider. Federal laws should be changed to allow for Medicaid reimbursement to all rural health centers including those which are supported by federal funds.

5. Rural health providers should determine the limits on practice by primary health practitioners and as necessary push to remove restrictions. This process requires a clear understanding of the legal status of practitioners and the scope of permitted services. Further, it requires action to bring the law into conformance with the practice.

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